

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN6501</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>07/02/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF MORGAN COUNTY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>419 SOUTH KINGSTON STREET WARTBURG, TN 37887</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies  During the annual Licensure survey conducted on June 30, 2014, through July 2, 2014, at Life Care Center of Morgan County, no deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 002			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Signature]*

*Executive Director*

*7/16/14*

STATE FORM

6899

V9HZ11

If continuation sheet 1 of 1

JUL 21 2014